California Rural Health Policy Council Public Meeting Summary
Friday, March 23, 2001
Fish Camp, CA

Council representatives:

David M. Carlisle, M.D., Ph.D.	Director, Office of Statewide Health Planning and Development (OSHPD) Acting chairperson
Kimberly Gates	Assistant Secretary, California Health and Human Services Agency
Morgan Staines	representing Kathryn Jett, Department of Alcohol and Drug Programs - Staff Counsel
Mauricio Leiva	representing Sandra Shewry, Managed Risk Medical Insurance Board - Rural Demonstration Project
Diane Ford	representing Diana Bontá, Department of Health Services - Licensing and Certification
Frank Vanacore	representing Diana Bontá, Department of Health Services - Audits and Investigation
Mel Voyles	representing Stephen Mayberg, Department of Mental Health - Systems Planning, Development and Evaluation Chief
Maureen McNeil	representing Richard Watson, Emergency Medical Services Authority - Emergency Medical Services Chief
Fred Johnson	Executive Director, California Rural Health Policy Council

Meeting begins: 8:30 a.m. - David M. Carlisle, M.D., Ph.D., Chairperson

Self introduction of panel members.

Dr. Carlisle thanks the California Healthcare Association for partnering with the California Rural Health Policy Council to make this Public Meeting possible. Dr. Carlisle also mentions his visits to rural hospitals of California's southern region and hopes to make it to many of the rural hospitals and clinics in the near future.

Morgan Staines of the Department of Alcohol and Drug Programs makes a presentation on Proposition 36 - Substance Abuse and Crime Prevention Act of 2000.
(See attached of Mr. Staines' Power Point presentation.)

Update on the California Rural Health Policy Council's Activities:
Fred Johnson, Executive Director

Latest newsletter is now out. The California Rural Health Policy Council office has moved to 818 K Street, Room 210. Our 800 number has remained the same. The office now administers both the Small and Capital Grant Programs and the Critical Access Hospital Program. Our next meeting will be held May 3, 2001 in Eureka, CA with the Northern California Rural Roundtable.

We are soliciting comments for both the CRHPC Small and OSHPD Capital Grant RFA. We have both the RFA's from the last cycle and a 5 page packet with issues raised by

applicants that are available to you. Our intent is to hear from you and make Policy decisions by both the Policy Council and Dr. Carlisle whose office administers the Capital grants. We will release the RFA's as soon as we are assured that the money is available and get the awards in place by the summer.

Public comment:

1. Mike Barry, Administrator, Plumas District Hospital, Quincy CA
   a Ask support of the CRHPC for legislation to be introduced by the California HealthCare Association to delay earthquake safety regulations. Article II SB 1953. These regulations require bracing for all systems for communications, emergency power, bulk medical gas, fire alarms and exit lighting by 2002. Our hospital submitted structural evaluation report to OSHPD over 1 year ago. Our cost to meet the 2002 standards are $300K. Even if the work could be done, we would have to tear out all work just completed, when we start to redo our entire hospital for the upgrade.

   b For the last 18 months our architect has been working on construction plans to upgrade our hospital to meet 2030 requirements; add a 2nd surgery room and expand the Emergency Department. Estimated cost of construction is $4.0 million. It will take an additional year for the plans to get through OSHPD before we can start construction.

2. No name on second testimony card
   a. Continued need for Small Grant funding and Capital Grant funding. Critical for rural clinics.
   b. Funding for drug and alcohol programs directly to clinics who have funding in place.
   c. Change in licensing that allows mid-level physician assistants to supervise medical assistants without R.N.'s present. This is critical due to nursing shortage.
   d. Change in licensing regarding M.D. of rural clinics who have hospital privileges.
   e. PIC program requirements needing a dispensary certificate before participating - this is a disadvantage to small rural clinics who cannot meet all the regulatory requirements.
   f. Funding needed to rural clinics and hospitals to implement HIPPA requirements.

3. Ned Miller, Bloss Memorial Healthcare District
   a. Electronic Data Systems (EDS) problems. Are people still having payment problems through EDS?
   b. Can you check with some state department if other facilities are have problems with Helsman as a Workers Comp carrier? Bloss' Workers Comp turned in occupational status reports on time, Helsman denies claims with copy of report attached stating that they need a first report. Feel it is a delay tactic. Over $10K due from claims over 60 days old from this company. Denied due to under investigation, but never get back to us and tell us the investigation is complete and say when they will pay us. Is there some state agency that can intervene?
   c. Licensing and certification problem with Medi Cal agreement for radiology.

Morgan Staines suggests: Contact Department of Insurance regarding the problem with the carrier. They have the capability to look at complaints like that. The Dept. of Insurance has new key staff that are very effective and formerly from DADP.

4. Thaine Allison, Independent Health Economist

The governor announced a $50m grant for rural farm workers. What does it mean, how does it work, are forest workers considered agriculture workers?

5. Dave Anderson, Lassen Community Hospital

a. Sole community providers depended upon by communities for health and economic welfare
b. Energy crisis: besides electricity, increase in natural gas propane and fuel oil. Lassen electric rate increased 41% and will increase again. We will add 100k to expenses this year. Will lose another 100k in bad debts who cannot afford increase in energy costs and must pay their energy bill before paying their medical bills. Will need to cut 200k of low priority items and services that aid community. Can't get into rate structure this year.
c. Need to recognize that the cost of doing business will find its way into hospital rate structure. All payors including Medi-cal need to increase payments to hospitals.
d. Seismic safety act: Results are in and most rural hospitals are classified as SPC1, NPC1. Hospitals that money spent on retrofitting obsolete aging facilities would be more cost effective spent on new hospitals or new facilities or a new addition. Each community must decide the level of care they can support given the new economics. Sole community providers are particularly at risk to maintain acute care services.
e. Most essential facilities do not have reserves to provide equity for construction nor is annual net increase enough to pay for additional debt service and they don't qualify for loans. Cannot pay them back, unless community have tax rate or guarantee for payment. Recommendation: provide sole community providers grants to supplement loans and community taxes. Hospitals under construction should be allowed extension on Jan 2002 for NPC2. Need to recognize that dollars in hospital will go into rate structures and increase cost of health care in the state.
f. Impact of professional staffing requirements on rural facilities: had to pay prem pay to attract and maintain pharmacists to compete with retail pharmacies. Temporary suspend sleep studies due to resp ther vac. Farm out lab tests to community labs because of lab tech vacancy which was created by the dept of ph, who hired competent lab tech.
g. Nursing shortage last month - ICU beds in suspension due to lack of critical care nurses.
h. Directly impacting services to communities. Pay Registry nurse exorbitant wages. Need to create pool of professional health care people. ICU waiver denied by L&C that have to have 2 licensed personnel when unit is open. 48 nursing hrs per patient day is impractical and not viable.
i. No state school should be allowed nursing program and jeopardize health care system.
j. Nursing should have standard curriculum to allow for transfer of credits and matriculation of students from LVN to ADN to BSN. Programs of financial support in allied health professions and nursing staff ratios adopted by DHS

should be realistic, but not excessive and guarantee financial failure of rural hospitals.

k. JACHO. Only state which commission had agreed to include DHS and CMA in survey process. Lassen Community has been accredited for decades. May 2000 survey included: 3 surveyors from JACHO, 4 surveyors from DHS,2 surveyors form CMA. Spent 23 survey days at Lassen, 28 beds, rural hospital, no stone left unturned. DHS under contract with HCFA to do Region IX surveyors. HCFA surveyors were surveying DHS surveyors. DHS surveying same work done with Joint Comm earlier. Title 22 standards, standards on accreditation, Medicare standards of participation. More surveyors than patients. Suggestion that DHS as a regulatory agency, and CMA and trade org have no business in Joint Commission Survey. DHS has no business conducting validation survey on an accreditation survey on which they participate. Conflict of interest. Need to change law.

l. Rural Hospital subjected process equivalent to big hospitals. Need to recognize difference between rural and urban hospitals.

Diane Ford: Regulatory authority requires that JACHO requires California's process tri-entity to do survey altogether. HCFA requires validation survey in 5% of surveys done that year and Lassen fell into that 5%.

6. Harold Carlson, Del Norte Clinics

a. HPSA designation process: California should take proactive role in creating HPSA regulations that work for California shortage areas. Project under way was one of 7 pilot projects in the nation working with Feds on restructuring designation criteria. Not just used for 330 funding and Rural Health Clinics.

b. Small grants and capital grants. Have been very good. Glitch in process needs to be corrected. When RFA was received were assured that separate licensed clinics could apply by site and not by organization. We were awarded in the past by site. The last couple of year's body has decided that grants would be made by organization. Only applicant in some counties where counties and hospitals don't apply. Needed for migrant school children health screening and dental programs. Needed for parking lots when cities require more parking to expand services. How should we apply: for one site only? By organization?

Dr. Carlisle: HPSA process handled in California by OSHPD and is enormously complex. The Division of Shortage Designation is still in process of evaluating criteria for shortage area designation. OSHPD is taking a look at streamlining process so that it's easier for applicants.

7. David Mechtenberg, Ridgecrest Regional Hospital

a. Nursing shortage and tech shortage. Seismic issues. Nursing ratios impossible to meet because of nursing shortage. BBA. Energy crisis.

b. AB60 - Non-exempt must take a 30 min consecutive lunch break and registered daily. If not done, hospital pays 1 hr start time and a penalty charge of 1/2 hr to that employee. Employees who clock in and clock out and get interrupted and take 10 min and then come back for 10 min. Creates staffing problem because of coverage. For a small facility must find other resources to take care of patients when a nurse is at lunch. Law is inflexible. All hospitals are struggling and one shoe does not fit all.

8. Berney Hietpas, Glenn Medical Center
   a. CHA hospitals - Medicare program may save some hospitals. Medicare funding is not enough will see 70,000 to bottom line, but in a small hospital it will only make up a little of deficit. Possible solution is to have Medi-Cal participate. Governor blue lined those items. Encourages CRHPC support for Medi-cal participation to Governor.
   b. Need for quicker action on part of L&C for CHAs. Only 1 far No California hospital survey completed in past year. So California has seen more activity. Process is extremely slow. Hospital has to wait for return of statement of deficiencies and may take weeks or months before hospital is notified. Hospital has to respond. If satisfactory, then designation is made and only then does the funding start. Needs process to be much faster.

9. Donna Donald, Southern Inyo District Hospital
   a. Grant applications due by Friday night. Not to be looked at until Monday. Accept postmark date. Providers live in terror that the completed is not going to get there in time.
   b. Title 22 should be looked at very carefully - one size doesn't fit all. Committee worked with DHS a couple of years ago and some changes were made, but needs review again.

10. Ray Hamby, Hill Country Clinic
    PPS - Allow clinics to choose to continue to receive cost-based reimbursement for Medi-Cal. PPS Takes 1999 and 2000 rates together and averages them for the new rate, retroactive to 1/1/01. DHS has until 3/31 to submit conforming plan amend for their by which they submit their intentions to HCFA on PPS implementation. Fed statute allows alternative pay method as only criteria that they not pay less than PPS pays. State is implementing PPS without allowing CB reimbursement; removing that facility-specific reimbursement would endanger safety-net provider in isolated areas. CB reimbursement is tailored to each clinic. Urge DHS to allow choice of reimbursement methods in conforming plan amendment. Some clinic would benefit from PPS, but that's on average.

Frank Vancore: If you have concerns on state plan amendments, want to hear from you.

11. David HitchockAspen Street Architects
    SB1953 - Rural Health Design Consortium - group of 11-15 hospitals, rural and frontier to form a slightly bigger bug on windshield to get grant funding. Using SB1953, we looked at their facilities and it does not make sense to put money back in. They need to obtain grant funding to do that. Going to foundations for money and we will be coming to state's doorstops.

Dr. Carlisle: OSHPD's Facilities Development Division has worked with the consortium.

12. Vivian Fernandez - Redwoods Rural Health Center/North Coast Clinic Network
    a. Prop 36 - Behavior health issue, need staff to health service delivery service. Clinical licensure, master's level clinicians may not be able to be licensed or to have internship to gain hours to be licensed. When having to deal with involuntary inpatient services with substance abuse/mental may have to engage sheriff departments that are ill-equipped to deal. Allow greater flexibility in licensing master's level clinicians and telemedicine services to psychiatrists and

psychologists and that MDs are not always skilled in mental health issues. Need multi-dispensitory team that includes bachelors level trained in substance abuse issues to meet needs of rural and frontier sites.

13. Don Kazama, Energy Engineering Consultant
Assist RHPC constituents in identifying funding sources made available through current legislation for implementing energy efficiency measures to reduce operating costs. Identify appropriate projects to implement to save 10% - 20% electrical utility bill. Put energy consortium together to bid on some sources through the California Energy Commission www.energy.ca.gov . Public Utilities Commission at www.cpuc.ca.gov for tracking funding for energy projects.

14. Sharon Farr,Central Valley General Hospital
Mobile van certification - Diane Ford called and discussed problem, has anything happened? Would like to have van certified. Still not a mobile van. Sites need to be certified. Just received grant for diabetes study. Need to go to farm workers; they can't come in. Need to use mobile van.

15. Paul DyerMemorial Hospital - Los Banos
EMS/trauma funding. Local specialist won't treat because of low reimbursement. Inadequate specialty treatment in Central Valley. Patients go to local ER and then go home. No specialist on call at local hospital. ER must coordinate with trauma center in Modesto. Many times care could be performed at local specialists (low reimbursement). Other hospital does not have specialists covered. Orthopedists are not willing to take patients. Increased delays in registration. Reluctance on specialists to take ER calls because they are medically indigent. Docs won't do charity care. Change in attitude. Average stipends cost $1,000/day, very expensive for hospitals. Hospitals can't pay ER call compensation. Rift between administration and medical staff on issue. If they refuse to take call, and there is hole in the coverage. The solution more state/federal programs. To recruit specialists, NP in rural areas. Increase payment to MDs. Docs look to hospitals to pay for specialty coverage. Urge DHS to engage with CHA and CMA to develop plan to identify areas of greatest need. Not just hospital's responsibility to pay for this.

16. Walt Beck, Mee Memorial Hospital
Title 22 revisions - be reviewed from a rural perspective. This must be done before facilities are replaced. Attempt to put together a document that reflects the business market at this time. No other industry would function under laws that are 30-40 years old. Replacement of hospitals that are based on regulations that don't reflect current situation.

17. Heather Mandell, Georgetown Family Medical Center
    a. EDS problems, still working on, EDS sent out a program specialist to speak with them but then no follow-up.
    b. Went to Medi-Cal 2000 and found EDS mucky muck and is helping to solve problems.
    c. Systemic problem.
    d. Grants - small clinic can't compete in grant writing. Solution: to make sure grant funds gets out is to move forward with frontier designation and pull out funds that are set aside for frontier.

e. Midlevels should be able to supervise Medical Assistants.

18. Irving Gray, Rural Health Clinic Consultant
    a. Expand grants for "for profit" clinics.
    b. Need capital for new Rural Health Clinics.

19. Belinda Cano, Central Valley General Hospital, Rural Health Clinics
    Need to have clear guidelines whether or not multiple sites will be funded or give an option of submitting one grant to include all sites but allow same amount for each clinic.

20. Kevin Erich, Howard Memorial
    a. AB 60 lunch breaks
    b. Staffing ratios - other hospitals close due to no staff and refuse patients
    c. CAH - going through process. Must have Medi-cal participation. ER Medi-cal pays $.20 on the dollar, increased only to $.26
    d. OSHPD small project waiver "SB" small project 4' wall w/door - can't use room.
    e. Seismic = going to cost $24 billion, not 1 person died in last 30 years; $ could be spent better.
    f. Energy blackouts - hospitals <100 beds need to be exempt.

21. Linda Norgaard, Volunteer Grant Writer
    Inadequate reimbursement for hospice services. Medi-Cal $108 flat rate per day covers only 60% of actual costs. Mandated bereavement services for family members (sometimes 4-5) for 13 months following death is include in patient day reimbursement. Physicians are referring patients too late. Trying to raise $1.3 million/yr.

22. Eric Martinsen, Central Valley General Hospital
    Rural hospitals under 50 beds have received cost reimbursement for Medi-Cal serves. Under BIPA the payment becomes perspective unless the state plan provides for continued cost reimbursement.